State of Utah
Department of Human Resource Management

CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993)

Employee: _____ Date: _____

Individual with medical condition: Employee ( ) Family Member ( )

Family Member's Name: _____ Relation: _____

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: This certification will be used to determine employee eligibility for FMLA leave due to either the employee's own or a family member's "serious health condition". The attached Terms and Definitions describe what is meant by a serious health condition under the Family & Medical Leave Act.

THE INFORMATION SOUGHT ON THIS FORM RELATES **ONLY** TO THE CONDITION FOR WHICH THE EMPLOYEE IS TAKING FMLA LEAVE.

1. Does the patient's condition qualify under any of the following categories? (Each category definition is described on the attached Terms and Definitions.) Please check the most applicable category.

   - ☐ Hospital Care
   - ☐ Absence Plus Treatment
   - ☐ Pregnancy
   - ☐ Chronic Conditions Requiring Treatment
   - ☐ Permanent/Long-term Conditions Requiring Supervision
   - ☐ Multiple Treatments (Non-Chronic Conditions)
   - ☐ None of the Above

2. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of the category checked in #1:

_____

_____

_____

_____

3. Indicate the following:

   a. The approximate **date** the condition commenced:_____
   b. The probable **duration** of the condition:_____
   c. The duration of the patient's present **incapacity (*see below)**:_____

*****For purposes of FMLA, **incapacity** means the inability to work, attend school, or perform other regular daily activities due to a serious health condition, treatment thereof, or recovery therefrom.

4. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition? ____Yes ____No
   If yes, indicate the approximate length of time:_____

5. If the condition is a pregnancy or a chronic condition (see Terms & Definitions), state whether the patient is presently incapacitated and the likely duration and frequency of episodes.

_____

_____

_____

6. If additional treatments will be required for the condition, list the treatments and estimate the probable number of such treatments:

_____

_____

_____

_____

   a. If any of these treatments will be provided by another provider of health service (e.g., physical therapist), please state the nature of the treatments:

_____

_____

_____

   b. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment):

_____

_____

_____

7. ***Complete this section if leave is required for the employee's own condition.***

   a. Is the employee unable to perform work of any kind? ___Yes ___No

   b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? ___Yes ___No

If yes, please list the essential functions the employee is unable to perform:

_____

_____

_____

8. Complete this section if leave is required for the employee to care for a family member with a serious health condition.

a. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? ___Yes ___No

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ___Yes ___No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____

_____

_____

Signature of Health Care Provider	Type of Practice
Address	Telephone

9. To be completed by the employee needing family leave to care for a **family member**:
State the care you will provide and estimate the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____

_____

_____

Employee	Family Member's Name	Relation
Agency/Dept:		Division

Employee Signature Date

Certification of Health Care Provider
Terms and Definitions

Incapacity – Incapacity for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

Treatment – Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examination, or dental examination.

Regimen of continuing treatment – A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Serious Health Condition – An illness, injury, or physical or mental condition that involves one of the following:

1. **Hospital Care**
   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**
   A period of incapacity of more than three consecutive days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves either of the following:

   Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

   Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. **Pregnancy**
   Any period of incapacity due to pregnancy, or for prenatal care.

4. **Chronic Conditions Requiring Treatment**
   A chronic condition which:

   Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   Continues over an extended period of time (including recurring episodes of a single underlying condition);

   May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. **Permanent/Long-term Conditions requiring Supervision**

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a sever stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**
Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care servides under order of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) sever arthritis (physical therapy), kidney disease (dialysis).